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# Fourth Circuit Affirms Abuse of Discretion Finding in Denial of Coverage for Long Term Disability Claim


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In an unpublished decision issued last month, the Fourth Circuit Court of Appeals affirmed a lower court's ruling ordering the reinstatement of long-term disability and life insurance benefits. On August 14, 2019, Mike Brittingham and I will dive into these types of issues in much greater depth during a one-hour webinar entitled Employee Benefits Compliance: Critical Steps to Take for Compliance and Risk Mitigation. You will find the invitation here.

In *Smith v. Reliance Standard Life Insurance Company*, No. 18-2225 (4th Cir. June 20, 2019), the plaintiff, Fredrick Smith, was forced to leave his position as plant manager at Charles Craft Inc. after almost 40 years due to a series of strokes and heart problems. His employer carried a group life insurance policy as well as a long-term disability benefits plan that included a life insurance premium waiver. Initially, the company enrolled Smith in coverage. However, after three years, and in the face of contrary opinions of his physicians, the insurer determined Smith was no longer totally disabled.

The company's decision was based on a couple of factors. First, when filling out Smith's application for disability benefits, even though his treating physician noted that he could "NEVER" return to work, he also checked a box on the form noting the availability of "sedentary work." Second, completing a continuing coverage form, another of the plaintiff's physicians noted that Smith "walks up to 40 miles without difficulty"; however, the form failed to acknowledge that measurement was a cumulative total measured over a five-month period.

Most notably, the insurance company relied on a third treating physician's notes, which were "formatted using voice recognition software." These notes contained a number of "generic positive statements" indicating Smith was "doing well from a cardiac standpoint" and had controlled blood pressure and blood sugars. Another note – which the court characterized as an "enigma" – said that despite his significant health issues, Smith was an active hunter going on "about 50 – ½ mild tracks" and could "walk 8 miles without discomfort and hunt without difficulty."

Smith appealed Reliance's denial of coverage, but the insurance company found he had exhausted his administrative remedies. Despite the lack of clarity in the physician's notes – which the physician acknowledged in a subsequent letter accompanying the appeal – Reliance determined its policies only allowed for one appeal, which was denied.

The plaintiff initially filed his claim in state court, but Reliance removed the case to federal court. There, the district court ruled in favor of Smith, finding Reliance ignored "a vast number" of his records.

On appeal, the Fourth Circuit first addressed the standard of review. It found that when the plan at issue grants the administrator discretionary authority to determine eligibility, the court must consider a number of factors first developed in *Booth v. Wal-Mart Stores, Inc.*, 201 F.3d 335 (4th Cir. 2000) when deciding whether the administrator's denial of coverage was an abuse of discretion. These include:

- The language of the plan
- The purposes and goals of the plan
- The adequacy of the materials considered to make the decision and the degree to which they support it
- Whether the fiduciary's interpretation was consistent with other provisions in the plan and with earlier interpretations of the plan
- Whether the decision-making process was reasoned and principled
- Whether the decision was consistent with the procedural and substantive requirements of the Employee Retirement Income Security Act (ERISA)
- Any external standard relevant to the exercise of discretion
- The fiduciary's motives and any conflict of interest it may have

The court focused on two primary factors: the decision's evidentiary support and the decision's reasoning. It found the record reflected that every doctor who examined Smith told Reliance he would never be able to work again. Instead, Reliance focused on what the court characterized as "stray comment[s]" that may individually reflect an ability to work, but when taken cumulatively with the record, were not sufficient to show Smith was able to work. The court took issue with Reliance's failure to address the mitigating and clarifying comments made by Smith's treating physicians in response to the insurer's initial denial of coverage.

Specifically, Reliance gave significant weight to treating physicians' comments that Smith was "doing well." The court found these comments to be "little more than boilerplate" and relative in nature. In other words, Smith may have been "doing well" for someone with many serious underlying health problems.

The court also rejected Reliance's assertion at oral argument that Smith would have to prove he could not perform sedentary work due to a physical limitation on activities like sitting, typing or speaking. It found this standard to be "quite … high" and would "erase disability for all but the bedridden."

## Takeaways

This case shows that even with the more deferential standard of review found in ERISA, courts will find an abuse of discretion where there is significant and substantial evidence supporting an employee's claim for benefits – and where that evidence is largely uncontradicted.

If you would like additional help thinking through these and other issues, please contact the Nexsen Pruet Employment & Labor Law group.

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